Kentucky Department of Veterans Affairs
Office of Kentucky Veterans Centers
1111 Louisville Road
Frankfort, Kentucky 40601
Phone: (502) 564-9281 Fax: (502) 564-4036

Dear Potential Resident/Family Member:

Thank you for your interest in the Kentucky Veterans Centers. We realize that the decision to place a loved one into a long-term care facility is not an easy one, and our goal is to make the transition as effortless and pleasant as possible.

At the top of the enclosed application you will find the names of the three state veteran's nursing homes we operate. Please check the box beside the home or homes in which you are interested in applying for admission.

There are admission coordinators at each home who are trained to assist, guide, and direct you through the application process. The addresses and telephone numbers of the admission coordinators are listed below, and we encourage you to contact them for any assistance needed.

In order to expedite the process, we have attached a list of items that are needed to help determine your eligibility, level of care, and financial responsibility. Please forward these items to us along with your completed application. Again, if any assistance is needed, please do not hesitate to contact one of the below facilities.

Thomson-Hood Veterans Center	Eastern Kentucky Veterans Center	Western Kentucky Veterans Center
ATTN: Admissions Coordinator LOVANNA RYSSEMUS Financial-Michael Horton	ATTN: Admissions Coordinator SHERYL DAY Financial- Nikki Begley	ATTN: Admissions Coordinator LISA WARE Financial-Lisa Foster
100 Veterans Drive Wilmore, KY 40390	200 Veterans Drive Hazard, KY 41701	926 Veterans Drive Hanson, KY 42413
859-858-2814	606-435-6196	270-322-9087
800-928-4838	877-856-0004	877-662-0008
FAX: 859-858-4039	FAX: 606-435-6201	FAX: 270-322-9497
TTYS: 859-858-4226	TTYS: 606-435-6203	TTYS: 270-322-9752

We appreciate your service to the nation and extend our gratitude for the opportunity to serve you, the veterans of America's Armed Forces!

Sincerely,

Mark A. Bowman, Executive Director
Office of Kentucky Veterans Centers

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☐ **Thomson-Hood Veterans Center**
100 Veterans Drive
Wilmore, Kentucky 40390

☐ **Eastern Kentucky Veterans Center**
200 Veterans Drive
Hazard, Kentucky 41701

☐ **Western Kentucky Veterans Center**
926 Veterans Drive
Hanson, Kentucky 42413

Please place a check in the box next to the home you are interested in.

No individual will, on the grounds of race, color, handicap, HIV status or national origin, be denied admission, care or any other benefit provided by the Kentucky Veterans Centers.

INSTRUCTIONS:

1. Applications must be TYPEWRITTEN or PRINTED IN INK.

2. Veterans must have anything other than a dishonorable discharge and meet those criteria required by the United States Department of Veterans Affairs for veteran's status.

3. Applicant must be a resident of Kentucky.

COUNTY OF RESIDENCE: Where is the veteran currently living/receiving care.	**DATE:**

In compliance with the eligibility requirements, I do hereby apply for admission to the Kentucky Veterans long term care facility checked above, and declare the following statements and information to be true:

NAME	**SOCIAL SECURITY NUMBER**
ADDRESS (STREET OR RFD)	**TELEPHONE NUMBER**
CITY, COUNTY, ZIP CODE	

DATE OF BIRTH	**SEX**	**AGE**
PLACE OF BIRTH		**RELIGION**

MARTIAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED (PLEASE PROVIDE DATES AND COPIES OF EACH)
☐ WIDOWED (PLEASE PROVIDE COPY OF DEATH CERTIFICATE OF SPOUSE)
☐ LEGAL SEPARATION (PLEASE PROVIDE COPY OF DECREE)

NAME OF SPOUSE (maiden name)	**SPOUSE'S SOCIAL SECURITY NUMBER**
SPOUSE'S ADDRESS	**SPOUSE'S DATE OF BIRTH**

DATE AND PLACE OF MARRIAGE (PLEASE PROVIDE COPY OF MARRIAGE LICENSE)

MILITARY SERVICE INFORMATION (Please provide copy of DD 214/Discharge)

BRANCH AND SERVICE NUMBER	**DATE AND PLACE OF ENLISTMENT**	**DATE AND PLACE OF DISCHARGE**	**TYPE Of DISCHARGE**

IF YOU HAVE EVER BEEN A RESIDENT OF THE KENTUCKY VETERANS CENTER OR OTHER STATE OR FEDERAL LONG TERM CARE FACILITY, PLEASE COMPLETE THE FOLLOWING:

DATE OF DISCHARGE	**FACILITY**	**REASON**

HAVE YOU BEEN A PATIENT IN A HOSPITAL WITHIN THE LAST SIX MONTHS? ☐ Yes ☐ No
If Yes, please complete the following:

Name of Hospital/Private Physician	**Address of Hospital/Physician**
Name of Hospital/Private Physician	**Address of Hospital/Physician**

DO YOU HAVE MEDICARE? ☐ YES ☐ NO **PART A_____PART B_____EFFECTIVE DATES:_____** **MEDICARE NUMBER _____(Provide copy)**	**DOES YOUR SPOUSE HAVE MEDICARE? ☐ YES ☐ NO** **MEDICARE NUMBER_____(Provide copy)**
DO YOU HAVE ANY OTHER HEALTH/MEDICAL INSURANCE: ☐ Yes ☐ No **COMPANY AND NUMBER_____** **(Provide copy & verification of premium due)**	**DOES YOUR SPOUSE HAVE ANY OTHER HEALTH/MEDICAL INSURANCE ☐ YES ☐ NO** **COMPANY AND NUMBER_____** **(Provide copy & verification of premium due)**

INCOME AND ASSETS

YOU HAVE TWO OPTIONS FOR PAYMENT; IF YOU CHOOSE NOT TO DISCLOSE YOUR ASSETS, PLEASE READ THE FOLLOWING STATEMENT AND SIGN:

I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. I UNDERSTAND THAT I WILL BE ASSESSED THE MAXIMUM AMOUNT FOR EXTENDED CARE SERVICES AND AGREE TO PAY THE MAXIMUM CHARGE.

SIGNATURE **DATE**

YOUR SECOND OPTION IS TO DISCLOSE YOUR ASSETS AND YOU WILL BE CHARGED BASED ON YOUR ABILITY TO PAY. IF YOU ELECT THIS OPTION, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

LIST ALL REAL ESTATE YOU AND/OR YOUR SPOUSE OWN OR IN WHICH YOU AND/OR YOUR SPOUSE HAVE ANY INTEREST. (Give location, size, description and approximate value. State whether held solely or jointly with husband/wife.)

LIST ALL SECURITIES WHICH YOU AND/OR YOUR SPOUSE OWN. (Include cash on hand or in safety deposit box, savings, checking accounts, time deposits, stocks, bonds, postal savings, notes, mortgages, or any other money or securities. Give amount and where located.) (Provide verification of all securities listed.)

LIST THE PERSONAL PROPERTY WHICH YOU AND/OR YOUR SPOUSE OWN. (Include auto, truck, livestock, furniture, farm equipment, business inventory, etc. Give approximate value and where located.)

LIST ANY INDEBTEDNESS OTHER THAN THAT SECURED BY YOUR PRIMARY RESIDENCE. (Include amounts, payee, due dates and reason for indebtedness.)

LIST ANY INSURANCE POLICES WHICH YOU AND/OR YOUR SPOUSE HAVE. (Include burial, life, hospital, health and accident. Give name of company and face and/or current cash value.) (Provide copies.)

LIST GROSS AMOUNTS OF MONTHLY INCOME:	**VETERAN**	**SPOUSE**
Wages	**$**	**$**
VA Pension	**$**	**$**
Service Connected Disability: _____ Percentage	**$**	**$**
Social Security	**$**	**$**
Medicare	**$**	**$**
Retirement Income	**$**	**$**
Pension Income	**$**	**$**
Other Retirement Income	**$**	**$**
Interest	**$**	**$**
Dividends	**$**	**$**
Income from rental properties	**$**	**$**
Court Mandated(Alimony, Child Support)	**$**	**$**
Other Income	**$**	**$**
Other Income	**$**	**$**

PERSONS TO BE NOTIFIED IN AN EMERGENCY. (List two. If applicant has a guardian, conservator, or power of attorney, copies of the legal documents establishing such authority must be attached.)	
NAME	**RELATIONSHIP**
ADDRESS	**WORK PHONE**
CITY, STATE, ZIP CODE	**HOME PHONE**
NAME	**RELATIONSHIP**
ADDRESS	**WORK PHONE**
CITY, STATE, ZIP CODE	**HOME PHONE**

BURIAL ARRANGEMENTS

Name of Undertaker to be called
Address of Undertaker
Desired Location of Burial
Name of person taking care of arrangements, if any

CERTIFICATION

I_____, do solemnly affirm that I fully understand requirements that must be met, and all qualifications that must be possessed by an applicant for admission to the facility. I fully understand all questions asked on this application and that all statements made by me on this application are true. I am a resident of the Commonwealth of Kentucky and affirm that because of physical disability, I am unable to continue living in my home. I further agree to accept transfer to any other health care facility, or to my home, if in the opinion of the staff such transfer is necessary. This application is my free and voluntary act.

I also certify that I have provided all requested information regarding my assets, indebtedness and income (including that related to my spouse) and that such information is complete and correct. I also agree to provide required proof of all income, assets, and indebtedness upon request. I understand that my admission and continued stay in the Kentucky Veterans Center is subject to a true and accurate reporting of my financial status. Misrepresentation of my financial status may result in my immediate discharge from the Kentucky Veterans Center.

I also understand that the professional staff at the facility shall have the right to deny admission if, in their opinion, my needs cannot be adequately met at the facility.

I understand that a non-medical leave of absence from the facility in excess of twelve (12) calendar days per year will result in a charge of the regular monthly charge plus the current VA per diem rate in effect at the time of absence. Absences from the facility will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period.

I understand that the resident is allowed ten (10) consecutive days during medical leaves of absence (hospital stays). Medical leaves of absence may occur more than once in a calendar year. A hospital stay will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period. Resident/Responsible party will be given the opportunity to continue to hold the bed at a charge of the monthly fee plus the VA per diem rate. In order to be eligible for a bed hold, the veteran must have established residency by being in the facility for thirty (30) consecutive days before leave is taken.

I hereby authorize the Kentucky Veterans Center to apply for any financial benefits to which I may be entitled.

I understand the monthly charges by the facility and agree to pay in full any charges within ten days of receipt.

Signature of Applicant **Date:**
(or Legal Representative)

Documentary support which must be provided prior to admission includes but is not limited to the following:

- **Medical records from all healthcare providers seen in the six months prior to application and extending to date of admission including recent hospital admissions.**
- **Verification of Kentucky residency, (mail items showing current address, utility bills, driver's license, etc.).**
- **Copy of power of attorney/guardianship papers.**
- **Copy of living will/advance directives.**
- **Copy of discharge from military service, (DD214), or other military document showing dates of service.**
- **Copy of military ID, if military retiree.**
- **Copy of social security card.**
- **Current history & physical, (within past 30 days).**
- **Current medication/treatment list, including herbal and over the counter meds.**
- **Current PPD skin test status or proof of negative chest x-ray.**
- **Current height and weight.**

If the applicant is currently in a nursing facility, please provide the additional information:

- **Nursing monthly summaries.**
- **Nursing notes for previous 3 months.**
- **MDS Assessment and Care Plan.**
- **Social Services notes.**
- **Diet information.**
- **Current medication list.**
- **Immunization records.**
- **Skin assessment.**
- **Recent lab reports.**
- **Proof of all income amounts listed herein.**

FINANCIAL INFORMATION REQUIRED FOR ADMISSION:

- **Verification of <u>ALL GROSS</u> income amounts applicant or spouse receive per month.**
- **Income from previous year (pensions, social security, interest, dividends, retirement)**
- **Total out of pocket medical expenses for prior year (Medicare premium, health insurance premium, co-pay for office visits, medications, eye glasses, hearing aids).**
- **Copies of check and check stubs applicant receives for income that is not directly deposited – gross amount before withholding.**
- **Copy of tax return for the previous year, if applicable.**
- **Copy of monthly premium paid on supplemental health insurance for applicant and spouse.**
- **Copies of last three bank statements for checking and savings accounts.**
- **Documentation of Market value of any property other than applicant's primary residence.**
- **Documentation of Market value of additional vehicles other than applicant's primary vehicle.**
- **Copies of Certificates of Deposit, IRA's, Stocks, Bonds, Money Market Accounts, Life Insurance Policies (cash value) and Burial Funds.**
- **Copies of outstanding debts, ie: medical bills, credit cards**
- **Copy of current marriage license.**
- **Letter from current nursing or most recent nursing home to verify financial obligation is being met or has been met.**

What To Bring?

Furniture and Room Furnishings

Television: All rooms are equipped with a TV mounted on a pivotal arm. It can be moved to watch TV from your bed or side chair. Personal TV's may not be brought in.

Furniture: Rooms are furnished with a bed, wall shelf, side chair, chest of drawers (the top drawer has a lock/key), and a nightstand. Personal furniture items may only be brought in with *prior* approval from the administrator. Closet space with a large drawer is provided for each resident.

Closets: Please help us keep closets neat and stocked with appropriate clothing. Please go through clothing items every few months, to make sure any torn/tattered items are removed and/or seasonal items are exchanged out. Closet space is limited and we want our residents to look nice and be comfortable at all times. Please remove any non-seasonal items or items that no longer fit.

*Please remember to give any new / additional items you bring in to the nurse manager or social worker so they can be labeled. New items will be sent to laundry for labeling after which they will be returned to the resident's room.

Electrial Devices: Rooms are equipped with electrical outlets. Extension cords or power-strips cannot be used in resident rooms. You may bring in a clock and/or radio but they must be in safe operating order, (ie: no frayed wires/cords, broken cases, etc.). Small electrical items must be inspected by our maintenance department for safety.

Personal Articles for Admission:

It is not necessary to bring a large amount of clothing as we launder clothes daily. To prevent cluttering and wrinkling in closets, we recommend only the items listed:

Shirts/Blouses	8-10
Pants/Slacks	8-10
Undershirts	10
Underwear	10
Socks	10 pairs
Belts/Shoes	2 each
Handkerchiefs	12
Housecoat	1
Pajamas/Gown	4
Sweaters/Light Coat	2 each
Winter Coat	1

The facility will label all clothing items for you with iron-on labels. Please be sure to take all new / additional clothes to the nurse manager or social worker to be labeled. Unlabeled clothing cannot be returned from the laundry.

The facility furnishes all blankets, bedspreads, sheets and pillows.

Wireless internet is provided for resident use. Laptops are the only type of computer allowed in resident rooms due to space limitations. Our library has computers for residents use.

Any *non*-clothing items, (such as pictures, radio, clock, etc.), will need to labeled with a *Sharpie* marker. We encourage you <u>NOT</u> to bring items of great value. If an item is lost, please notify your nurse manager or social worker as soon as possible. We will make a diligent effort to find the lost item and return it, but we are not responsible for lost/stolen items.

Food / Snacks: Residents may keep snacks in their room. The snacks must be kept in an air-tight container, dated and limited to small quantities. Close monitoring of all stored food items is important due to infection control.

Food items that require refrigeration should be checked in with nursing and labeled with the resident's name.

All nursing units have a kitchenette with a refrigerator for these items to be stored. We encourage residents/family to inspect their snacks frequently to make sure they do not become outdated or unfit for consumption.

Medications: THVC will obtain all medications needed for your loved one. Our medical providers monitor medications and adjust them as needed. Only medications prescribed by our medical providers are permitted. Our goal is to provide safe medication management while complying with federal regulations.

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OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

VA Medical Center
1101 Veterans Drive
Lexington KY 40502

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

THOMSON-HOOD VETERANS CENTER, 100 VETERANS DRIVE, WILMORE, KY 40390
PHONE# (859)858-2814 FAX# (859)858-4039

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

FAX COPY OF HINQ TO:(859)858-4039

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM JUL 2013 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.

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STEVE BESHEAR
GOVERNOR

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF KENTUCKY VETERAN CENTERS
THOMSON-HOOD VETERANS CENTER

100 VETERANS DRIVE
WILMORE, KENTUCKY 40390
(859) 858-2814
www.thvc.ky.gov

HEATHER FRENCH HENRY
COMMISSIONER

BENJAMIN R. SWEGER
ADMINISTRATOR

September 1, 2014

Dear Resident/Responsible Party:

On July 1, 2014, Thomson-Hood Veterans Center became dually certified for both Medicare and Medicaid beds.

Anyone unable to pay the monthly private pay room rate of $3700 is required to apply for Medicaid. Those residents, who pay the maximum charge of $3700 per month or those who VA pays 100% of their room and care charge, will not be required to apply for Medicaid.

In order to complete a Medicaid application, the resident or responsible party must provide considerable financial information as well as other legal documents. Attached is a copy of a Medicaid Checklist and a Medicaid Nursing Facility Services Fact Sheet. Please review the checklist and begin collecting the information required for the application as soon as possible. If you wish, you may start applying now by going to your local Department for Community Based Services Office. You can access this information by either calling (855) 306-8959 or visiting the below web address:

https://prd.chfs.ky.gov/Office_Phone/

If you have any questions, please call Michael Horton at (859) 858-3853 ext. 251.

Sincerely,

Benjamin R. Sweger, BS, MS, LNHA
Administrator

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MEDICAID CHECKLIST

This is a simple checklist to help you in preparing for your Medicaid interview. If one or more of the following items do not apply, go ahead and mark it off the list. When you obtain the necessary verification, simply mark an "X" next to it.

1. ____ Know the applicant's social security number and date of birth.

2. ____ Copy of Medicare Card and any other health insurance cards.

3. ____ Power of Attorney or Guardianship papers, if any.

4. ____ Social Security (or Railroad Retirement, VA, Black Lung, etc) benefit letter for the current year. We CANNOT accept the direct deposit amount as verification or the tax statement (must have official written documentation from the income's source). The phone number for Social Security is (800)772-1213. If the client or spouse has VA income, and part of the income is for Aid and Attendance, we will need written proof from VA of how much the income is from this source.

5. ____ Proof of any pension, rental income and/or farm income, etc. We will require either the pay stub for pensions or a letter from the pension agency. For rental income, we require the lease agreement and proof of expenditures, such as repair costs, tax bill, homeowner's insurance premium verification and a signed letter stating who receives monthly rental income.

6. ____ If the applicant receives an annuity payment, or has an annuity agreement, we need a copy original annuity contract and proof of how much income isreceived.

7. ____ For Long Term Care, if the applicant's gross income before any deductions is more than $2,022 per month, please provide a Qualifying Income Trust.

8. _____ ALL PAGES (if it says 1 of 6, we need all six pages even if one is blank) of the last 3 months' bank statements on ALL checking and/or savings accounts. **These bank statements must be consecutive!** We will also need the bank statement from the month of application. If you misplaced any of these, the bank can most likely furnish you with a printout.

9. ____ Proof of value of Certificates of Deposit, stocks, bonds and letter explaining the content of safe deposit boxes or any resource such as cash that you may have stored away.

10. ____ Copies of IRA's, 401K's, etc. and proof of any income received from such sources. If you are 59 Y, or older, you are required to take the minimum required distribution in order to be eligible for Long Term Care Medicaid. Please provide proof of how much the Required Minimum Distribution is and how much is being taken from the IRA or 401K plan.

11. ____ Copy of any Trust documents and proof of value of items in that trust.

12. ____ Copy of all life insurance policies. We need the face sheet, which shows the policy number, policy issue date and name of the insured. We also need the current cash surrender value of the policies. Some policies will have a table regarding the cash value. If it does not or if the table is too old to show current cash value, contact the life insurance company to gather this information.

13. ____ Copy of pre-paid funeral arrangements.
    a. Itemized goods and services sheet
    b. Proof of how the funeral is funded and how much has been paid or invested in the funeral

c. If the funeral was funded with cash and placed in a trust account, we need an Irrevocable Trust Agreement signed within 30 days of the application date.
d. If the funeral was funded with cash that was used to purchase a policy through a funeral home, we need a copy of that policy and proof from the policy company that the policy has been irrevocably assigned to the funeral home.
e. If the funeral was funded by signing over already existing life insurance policies, we need proof from the insurance companies that the ownership of each policy has been irrevocably assigned to the funeral home. We will also need a copy of each policy signed over to the funeral home.

14. ____ Proof of health insurance premiums. We need proof of the amount of the monthly premium and also proof that it is being paid. You can give us a letter from the company stating the amount of the premium but we also need to see you are actually making payments. We can accept copies of checks and direct withdrawal from a checking account as proof. Proof of Medicare Part D premium is also needed. This is the prescription plan.

15. ____ Provide the address where the applicant lived prior to entering the facility.

16. ____ Copy of tax bill for any homestead property or land owned along with proof of any indebtedness on the property.

17. ____ Proof of any assets transferred from the applicant and/or applicant's spouse in the last years.

18. ____ If applicant is married, please provide ALL of the above information for the spouse.

19. _____ If there is a spouse, who resides in the community, and you wish for us to consider their shelter and utility expenses, please provide utility, garbage, water, phone, mortgage or rent bill and proof of taxes and homeowner's insurance if home is owned.

20. _____ If applying for a minor child, please bring SSI denial letter, proof of all information above for each parent and sibling in the household, and a list of the child's medical providers, their addresses, phone numbers and treatments or medicine provided.

Note: Please be aware that effective 07/01/06, federal law requires all applicants for Medicaid to provide proof of citizenship. A copy of the Medicare card suffices to prove citizenship. If you do not have Medicare, please provide one of the following from each list, **ALL DOCUMENTS MUST BE ORIGINALS.**

List A

1. Driver's License
2. Any other official state issued identifying information

List B

1. U.S. Passport
2. Certificate of U.S. Citizenship
3. Birth Certificate
4. Certificate of Birth issued by the Department of State
5. U.S. Citizen ID card
6. Final adoption decree
7. Evidence of Civil Service Employment by the U.S. Government prior to 1976
8. Official military record showing a U.S. place of birth
9. A Northern Mariana Identification Card (Form 1-873)
10. Certificate of Naturalization

MEDICAID NURSING FACILITY SERVICES FACT SHEET

What are Medicaid Nursing Facility (NF) Services?

Nursing facility (NF) services included in per diem rate are room and board, dietary services, nutritional supplements, social services, activities, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, prosthetic devices, laundry services, drugs ordered by the physician and personal items routinely provided by the facility. Other services, if medically necessary and if ordered by the physician, are x-rays, physical therapy, speech therapy, occupational therapy, laboratory services, oxygen and related oxygen supplies may be billed separately from the per diem rate.

Who is eligible for Nursing Facility Services?

You may be eligible for nursing facility services if:

- You are age sixty-five (65) years or older, blind or disabled or are currently Medicaid eligible.
- You reside in a facility that participates in the Kentucky Medicaid Program and are placed in a Medicaid certified bed.
- You require and meet the nursing facility level of care criteria giving consideration to the medical diagnosis, age-related dependencies, care needs, services and health personnel required to meet those needs and the feasibility of meeting the needs through alternative or non-institutional services.

What are Resources?

Resources are cash money and any other personal property or real property that you own, may covert to cash and could use for support and maintenance. Resources include checking and savings accounts, stock or bonds, certificates of deposit, automobiles, land, buildings, burial reserves, life insurance policies, annuities, trusts and more.

We do not consider some resources in determining Medicaid eligibility. These resources include the home for the first six (6) months of institutionalization or if a spouse or dependent family member lives in the home, household goods and personal effects, the first $1,500 of a burial reserve or a life insurance policy, one automobile used for work, medical treatment or by the community spouse, burial spaces and plots, life estate interest and IRA's, Keoghs, retirement funds and other tax deferred assets (until accessed).

Your resources must be within Medicaid resource guidelines. The resource limits vary if you are married and we count your spouse's resources.

Marital Status	Services Being Received	Resource Limit
Single Person	NF Resident	$ 2,000
Married Couple	Both NF Residents	$ 4,000
Married Couple	**Note**: Includes $2,000 for the spouse getting waiver services	Minimum $24,728 to Maximum $115,640

What is a Resource Assessment?

You, your spouse or someone representing you may ask the Department for Community Based Services (DCBS) to make an assessment of your combined countable resources. You do not have to apply for Medicaid to get a resource assessment. The resource assessment involves documenting and verifying all countable resources owned by you and your spouse at the time of the most recent nursing facility admission. The assessment compares the combined countable resources to the current Medicaid limits to determine if you meet Medicaid resource guidelines. The assessment also sets the spousal share or the amount of resources your spouse may keep if you apply and are approved for Medicaid.

Contact DCBS in the county where you live to request a resource assessment. DCBS will give you and your spouse copies of the completed assessment.

What are Transferred Resources?

If you or your spouse transfers resources, you may not be able to get Medicaid nursing facility services. Transferred resources are cash, liquid assets, personal property or real property, which are voluntarily transferred, sold, given away or otherwise disposed of for less than fair market value on or after February 8, 2006 If DCBS determines there was a transfer of resources, a penalty period will be calculated and will begin the month the transfer was made or the day the individual is eligible for Medicaid, whichever date occurs last. It is up to you to prove the transfer was for a reason other than to be qualified for Medicaid.

What is Income?

Income is money received from statutory benefits (including Social Security, Veteran's Administration pension, Black Lung benefits, Railroad Retirement benefits), pension plans, rental property, investments or wages. Your income must be within Medicaid guidelines to get Medicaid nursing facility services. We consider your income, but do not count your spouse's income. The income limits may vary depending on the number of days you have received nursing facility services.

You are income eligible if your gross monthly income is at or below $2,094. If your income is over $2,094, you may become eligible by establishing a Qualifying Income Trust (QIT).

You may be required to pay part of the cost of your care. Patient liability is determined by considering your income and allowing a $40 deduction for personal needs, maintenance deductions for a spouse or family members and deductions for medical expenses and health insurance premiums. The amount left over is what you must pay to the nursing facility for your care.

How Can I Apply?

You or someone representing you may make a Medicaid application at the DCBS office in the county where you live. Bring proof of citizenship, identity, social security number, income, resources, health insurance cards and premiums and medical bills to the application interview. .